Mary Lou Devlin, LMFT
Psychotherapist
License #37377

Client Information Form **(Please Print)**

Client Name: ____ Today's Date: __________

Client Address: ____

City: _____________________________________ State: ___________ Zip Code: ________

Client Contact Numbers:		**Check Preferred Number**	**Check if Okay to Leave Message**
Home:	(_______) ___________________	( )	( )
Cell:	(_______) ___________________	( )	( )
Work:	(_______) ___________________	( )	( )
Other:	(_______) ___________________	( )	( )

Email Address: ____

Date of Birth: _________________ Age: _______ Marital Status: S M D W Sep

Spouse's Name *(if applicable)*: ____

Occupation: ____

Employer: ____

Do you have an insurance plan? ☐ Yes ☐ No

If yes, please provide the name and following information about the subscriber:

NOTE: *I currently do not accept insurance payments, but require the following if you wish to receive a Super Bill each month so you can personally submit to your insurance company for any potential reimbursement.*

Subscriber Name: _______________________________ Subscriber Date of Birth: ______________

Subscriber Address: ____

Subscriber Phone: (_____) ________________________ Relationship to Client: ________________

Name of Insurance Carrier: ____

Subscriber ID# __________________________________ Group # __________________________

Current Medications: ____

____

Current Physician: _______________________________ Phone: (_____) ________________

If someone other than client is responsible for payment, please complete the following:

Responsible Party Name: ____

Address: ____

City: _____________________________________ State: ___________ Zip Code: _________

Phone Number: (_____) ____________________

EMERGENCY CONTACT:

Name of Contact: ___________________________ Contact Phone: (____) ___________________

Relationship to Client: ____